Pursuant to 60A-1.042, an agency may request information by issuing a written Request for Information. Agencies may use Requests for Information in circumstances including, but not limited to, determining whether or not to competitively procure a commodity or contractual services, determining what solicitation process to use for a particular need, or researching general, special, and/or technical specifications for a solicitation.

Advertisement Detail

Department of Management Services
REQUEST FOR INFORMATION

Comprehensive Surgical and Medical Procedures Entity

RFI Advertisement Number: DMS-17/18-008
Begin Date: July 21, 2017
End Date: August 18, 2017

Commodities:
64122100: Health Insurance Contracts
64122101: Individual Health Insurance Policy
64122102: Group Health Insurance Policy
80101500: Business and Corporate Management Consulting Services
80101507: Information Technology Consultation Services
80101508: Business Intelligence Consulting Services
80111502: Compensation or Benefits Planning
81111902: Online Database Information Retrieval Service
85000000: Healthcare Services
85100000: Comprehensive Health Services
85101501: Emergency or Surgical Hospital Services
85101700: Health Administration Services
85101701: Health Policy
85101702: Health Legislation or Regulations
85101703: Health Service Planning
85101705: Public Health Administration
85101706: Traditional Healthcare Services
85101707: Health System Evaluation Services

I. INTRODUCTION

The Department of Management Services ("Department") Division of State Group Insurance ("Division") is issuing this Request for Information ("RFI") to the vendor community to obtain information regarding a future solicitation for comprehensive surgical and medical procedures (bundled healthcare services).

This is a RFI as defined in section 287.012(22), F.S., for planning purposes only. This is not a solicitation for offers. The information gathered from this RFI will be used to assist in the Department in the development of a competitive solicitation. Please monitor the Vendor Bid System for any changes or notices prior to submitting a response.

II. PURPOSE OF AN RFI

Rule 60A-1.042, F.A.C., provides that an agency may request information by issuing a written RFI. Agencies are authorized to use an RFI in circumstances including, but not limited to, determining whether or not to competitively procure a commodity or contractual services, determining what solicitation process to use for a particular need, or researching general,

special, and/or technical specifications for a solicitation. A vendor's response to an RFI is not an offer and the agency may not use the vendor's submission to justify a contract with that vendor without otherwise complying with chapter 287, F.S., and Rule 60A-1.042, F.A.C. Vendors submitting a response to an agency's RFI are not prohibited from responding to any related subsequent solicitation.

Any future purchase of the services will be conducted in accordance with chapter 287, F.S. The Department may use responses to this RFI to prepare one (1) or more competitive solicitations and as the basis for any subsequent vendor meetings.

III. BACKGROUND

Pursuant to section 110.123, F.S., the Division administers the State Group Insurance Program ("Program"). The Program is comprised of a package of insurance benefits, including health insurance options, flexible spending and health savings accounts, life insurance, dental insurance, and other supplemental insurance products for State of Florida employees and retirees, COBRA participants, and covered spouses and/or children. Each employee, retiree or COBRA participant that is the primary insured is an "Enrollee." Covered spouses and/or children are "Dependents." Each individual covered under the Program is a "Member." As of January 2017, the State Group Health Insurance Program covered 176,274 Enrollees and 367,681 Members.

Through the Program, the Department currently offers four (4) medical benefit plan design options. Two (2) of these are Preferred Provider Organization ("PPO") plans, while the other two (2) plans are either Health Maintenance Organizations ("HMO") or HMO-style plans.

The PPO options, available statewide, are currently self-funded, with medical benefits administered by a single third party administrator ("TPA"). The fully insured HMO and self-insured HMO-style options are currently provided by five (5) separate HMOs and TPAs, with a mix of fully insured and self-insured funding arrangements. A single pharmacy benefits manager ("PBM"), currently CVS Caremark, administers the pharmacy benefits for all plans with the exception of Medicare Advantage HMO plans, whose pharmacy benefits are administered by their respective fully insured HMOs.

The plan year runs from January 1st to December 31st of each calendar year, and open enrollment is typically scheduled during the last two (2) weeks of October.

On June 14, 2017, Governor Rick Scott signed Senate Bill 7022, which requires the Department to "contract with at least one (1) entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures…" The legislation requires the contracted entity to:

1. Have procedures and evidence-based standards to ensure the inclusion of only high-quality health care providers.

2. Provide assistance to the Enrollee in accessing and coordinating care.

3. Provide cost savings to the state group insurance program to be shared with both the state and the Enrollee. Cost savings payable to an Enrollee may be:

    a. Credited to the Enrollee's flexible spending account;

    b. Credited to the Enrollee's health savings account;

    c. Credited to the Enrollee's health reimbursement account; or

d. Paid as additional health plan reimbursements not exceeding the amount of the Enrollee's out-of-pocket medical expenses.

4. Provide an educational campaign for Enrollees to learn about the services offered by the entity

IV. GOAL

The Department seeks to understand the market and the scope of services for entities that provide comprehensive pricing and inclusive services for surgery and other medical procedures (bundled healthcare services). The Department is looking for organizations that will provide solutions to meet the state's current and future needs and is seeking responses to Section V, below.

V. RESPONSE

In order to develop a solicitation for comprehensive surgical and medical services, the Department is requesting the following information:

1. Your business organization's information.

    a. Business organization's name

    b. Primary contact

    c. Address

    d. Phone

    e. Email

    f. Whether your organization is licensed in the State of Florida, if so, what licensures.

    g. Whether your organization is registered to do business in the State of Florida, if so, what licensures, certificates, etc.

    h. Customer references from private and public entities, including any previous work with federal, state, local, or county governments. Please include number of covered lives for each reference.

2. Please describe the features of your benefit services, including:

    a. The type of healthcare services (e.g., inpatient, outpatient, medical, pharmacy, and behavioral health) included in your benefit service.

    b. The type of Member that may participate (Enrollee, spouse, 18+ years dependent, etc.).

    c. Whether your benefit identifies the cost and quality of healthcare services. If so, please describe how your service:

        i. Determines the cost of healthcare services. What data is used to determine the pricing? What type of healthcare services (e.g., facility, physician, anesthesia, pre-op/post-op, follow-up care, i.e. therapies) are included? How often is the cost of a particular healthcare service determined or updated? Is the cost of healthcare services determined per county or other geographic region?

ii. Determines the quality of healthcare services. What data sources are used to determine quality? Are patient reviews a part of the quality determination? If so, how much weight are patient reviews given when measuring quality? Are the patient reviews from other Members of a particular health plan or from a broader base? What safeguards are in place to prevent non-authenticated/non-verified users?

d. Whether your benefit identifies the cost and quality of healthcare providers and facilities. If so, please describe how your service:

i. Identifies available healthcare providers and facilities within a Member's health plan network. How often are network healthcare providers updated?

ii. Determines the quality of healthcare providers and facilities. Describe any independent research or reviews of healthcare providers and facilities that you undertake. What data sources and/or metrics are used to determine quality? Do you utilize any independent, third parties to evaluate quality? Are patient reviews a part of the quality determination? If so, how much weight are patient reviews given when measuring quality? Are the patient reviews from other Members of a particular population or from a broader base? What safeguards are in place to prevent non-authenticated/non-verified users?

e. A list of your network of healthcare providers available under your benefit services and in the State of Florida. Is the network exclusive to your organization or does your organization utilize the network of existing carriers/TPAs? How do you determine whether a provider will be included in your network? Is your network composed of physicians, facilities, free standing surgical centers, etc.? What happens when a network provider is also a network provider under the Member's health plan? What happens when a network provider is not a network provider under the Member's the health plan?

f. The bundled services offered.

i. What particular healthcare services are bundled under your plan? Would you recommend starting with a comprehensive list of services or starting with a limited number and then adding services as necessary? Do you have a plan that identifies covered services and/or exclusions? If so, please identify covered services and/or exclusions. Does your organization review claims data to tailor the services that would be bundled and offered? What is covered in an episode of care for each bundled healthcare service? Is there a specific time frame attached to the bundled healthcare services, for example physical therapy which could last several months after a surgical procedure?

ii. What data is used to determine the bundled services and pricing? How often is the cost of a particular healthcare service determined or updated?

g. How your benefit services cover or handle surgical complications. How does your benefit services directly connect and identify a subsequent service as a surgical complication?

h. Whether your organization provides medical necessity review prior to a surgical procedure. Do you utilize medical guidelines and/or physician review? Do and/or can you use the Enrollee's medical plan's medical policy guidelines? Do and/or can you use the medical plan's definition of medical necessity?

i. Whether your benefit is able to calculate savings (or cost avoidance) based upon a Member's particular selection of identified healthcare services. If so, what methodology do you use in order to determine savings?

j. Whether you offer the ability to share savings with Enrollees or Members. If so, please describe:

   i. The methodology(ies) used in order to determine amount to be shared with the Enrollee. Are there different methodologies regarding self-insured and fully-insured Enrollees. Is there a methodology(ies) by which self-insured Enrollees and fully insured Enrollees could realize the same cost savings? Are there different options available for Enrollees to participate in cost sharing?

   ii. The mechanism(s) by which savings are shared with Enrollees and/or Members. How are savings shared with Enrollees? Do you coordinate the transfer of credits or dollars directly to a Member or a Member's account? What type of accounts (e.g., flexible spending account, health savings account, health reimbursement account, etc.)? Do you offer the ability to transfer into different accounts for different Enrollees? Do you offer the ability to manage just a health reimbursement account for cost sharing purposes and what would the health reimbursement account set-up and annual administrative costs be? Describe the process and the type and source of data you need from each Enrollee to establish a health reimbursement account. Define the estimated time to establish new accounts after receipt of required Enrollees' data. How often are savings shared (e.g., weekly, monthly, annual lump sum)? Are funds held in an interest-bearing account until they are shared? Does your organization interface with flexible spending / health reimbursement / health savings account administrators? If so, please list two (2) to savings account administrators with whom you have worked in a similar fashion to share savings with Enrollees.

k. Whether your benefit provides online education and information to Members, including:

   i. Member-specific cost-share information, such as deductibles, copays, and out-of-pocket expenses regarding the health plan and prescription drug plan. How is this information generated in your system? How often this information is updated?

   ii. Whether your services steer Members toward wellness or other initiatives.

   iii. Any other healthcare education your benefit provides to Members.

l. Whether you offer a mobile-based platform. If so, please describe the functionality of the platform, including any notifications. Are there any benefit services or information that you offer for which you are unable to provide through the mobile-based platform?

m. What Members are covered under your benefit services (e.g., adults, Enrollees, dependents, etc.)?

3. Please describe how claims are adjudicated. Does your service integrate with Members' existing healthcare plans so that the existing healthcare plan will have information regarding the Member's treatment, cost-share, etc.? What frequency of data exchange with the health plans would be necessary so that the Enrollee's out-of-pocket cost share accumulations (deductible, coinsurance, etc.) would always be current? Would your service integrate with the state's health insurance management information system (HIMIS) claims database?

4. Please describe the claims denial procedure. What type of support could you provide the State of Florida regarding claim denial hearings?

5. Please describe how you demonstrate savings to your clients. What is the average amount of savings (or cost avoidance) that you have experienced during years one, two, and three

of an initial contract period? What methodology do you use to determine savings? How are complications factored in to the rate of savings?

6. What is the average amount that a participating Enrollee (or Member, as applicable) will save and/or what is average amount reimbursed / shared with the Enrollee (or Member, as applicable)?

7. Please provide information regarding Member utilization. What is the average Member utilization during years one, two, and three of the initial contract period? What percentage of Members engage your services on your traditional website? What percentage use your mobile-based platform?

8. Please describe communication and education strategies that you use in order to inform Members of your benefit services. Do you use demographic targeting strategies? What type of communications do you use (e.g., email, direct mail, etc.)? Do you use any strategies or incentives to increase Member participation?

9. Would you provide a dedicated representative to service the State of Florida account?

10. Please describe your customer support services for Members. What options are available to Members who need assistance with your benefit services (e.g., telephone, email, online including Chat assistance)? How do Members enroll in your benefit services? How do you support the need for multiple languages, the visually impaired, and the hearing impaired?

11. Please describe the pricing structure of your benefit services. Would your organization offer its services on a contingency basis (i.e., the Department would pay for your services based on a percentage of savings or cost avoidance)? What other type of pricing structures are available?

12. What is the average return on investment that your clients realize?

13. Do you interface directly with the carriers/TPAs/PBMs? What information do you share with carriers/TPAs/PBMs? Please identify any carriers, TPAs, and PBMs with which you currently have agreements. What are the interface or connectivity requirements for the carriers/TPAs/PBMs?

14. Please identify and describe any interface or connectivity that you would require with the Department's health plans, prescription drug plan, flexible spending / health reimbursement / health savings account administrators, and health insurance management information system (HIMIS). What are the interface or connectivity requirements for the carriers/TPAs/PBMs?

15. If your organization were selected for contract, please describe your organization's contract implementation processes.

    a. Please describe each phase of implementation and the estimated time for each phase.

    b. Identify any typical implementation difficulties that you typically experience.

    c. What is your recommended go-live date (e.g., at the beginning of the plan year, during open enrollment, etc.)?

    d. How long after being awarded the contract would your organization be ready to conduct pre-planning session(s)?

16. Describe any aspects of your benefit services that are unique to your organization. What differentiates your company's services from what other companies provide?

17. Please describe your organization's physical and information technology security protocols for the protection of confidential information, including protected health information under the Health Insurance Portability and Accountability Act.

18. Please provide any additional information about your organization, benefit services, and/or the marketplace that could assist the Department in the development of a solicitation to ultimately meet the requirements of the legislation.

VI. RESPONSE FORMAT

Potential vendors should respond at least to the following sections at a minimum:

a) Introduction;

b) Background;

c) Contact Information (company name, phone, email); and

d) Response to Section V.

PLEASE NOTE: Any submitted material is subject to the Public Records Act, section 119.07, F.S. See Section XIII, below.

VII. RESPONSE SUBMISSION

Responses should address each request and question in Section V, point by point. Responses must be submitted in both Microsoft Word and portable document format ("PDF") on a compact disc ("CD") or USB thumb drive labeled with Respondent's organization's name and the RFI number.

Respondents must submit three (3) hard copies of the Response, one (1) redacted copy (if applicable, see Section XIII, below), and one (1) CD or USB thumb drive to the Procurement Officer noted below within the required date and time, identified in Section X, below. The response must be submitted to the Procurement Officer at the address identified below:

Department of Management Services
Departmental Purchasing
ATTN: Maureen Livings
4050 Esplanade Way, Suite 335
Tallahassee, FL 32399-0950

VIII. PROCESS

Responses to this RFI will be reviewed by the Department for informational purposes only and will not result in the award of a contract.

The Department will review the responses to assist in the development of competitive solicitation for comprehensive surgical and medical procedures (bundled healthcare services).

Any request for cost information is for budgetary purposes only.

If necessary, the Department may request presentations from one or more of the responding vendors.

Responding to the RFI does not prevent a vendor from being eligible to contract with an agency pursuant to section 287.057(17)(c), F.S.

IX. PRESENTATIONS

After the Department receives responses to this RFI, and at the sole discretion of the Department, one or more Respondents may be selected to demonstrate to the Department the Respondent's products and services relating to the information submitted in the RFI response. The purpose is to learn about the most current solutions available. The meeting moderator will be polite but direct in an effort to keep discussions on topic and will not allow the meetings to take on a sales tone. Vendors are encouraged to bring technical and legal representatives to the presentation meetings.

X. TIMELINE

Listed below are important dates and times when actions should be taken or completed. If the Department finds it necessary to update any of the dates and, or times noted, it will be accomplished by an Amendment to the RFI. All times listed below are in Eastern Standard Time (EST).

Date	Time	
07/21/2017		Release of RFI
08/04/2017	4:00 p.m.	Questions due to the Procurement Officer
08/11/2017		Answers to vendor questions are posted to VBS
08/18/2017	3:00 p.m.	Responses are due to the Procurement Officer
TBD, the Department will schedule at their discretion.		Presentations, if applicable

XI. AMENDMENTS TO THE RFI

DMS will post amendments to the RFI on the Florida Vendor Bid System (VBS) at http://vbs.dms.state.fl.us/vbs/search.criteria_form. Respondents may view amendments by selecting "Department of Management Services" in the "Agency" drop down box. Each Respondent is responsible for monitoring the VBS for new or changing information.

XII. RFI QUESTIONS AND CONTACT WITH DMS

Respondents shall address all questions regarding this RFI in writing to the Procurement Officer identified in Section XV. The Department will post answers to questions on VBS as noted in Section X.

XIII. CONFIDENTIAL, PROPRIETARY, OR TRADE SECRET INFORMATION

If a Respondent considers any portion of the documents, data, or records submitted in response to this solicitation to be confidential, proprietary, trade secret, or otherwise not subject to disclosure pursuant to Chapter 119, F.S., the Florida Constitution, or other authority, the Respondent must mark the document as "Confidential" and simultaneously provide the Department with a separate redacted copy of its response and briefly describe in writing the grounds for claiming exemption from the public records law, including the specific statutory citation for such exemption. This redacted copy shall contain the Department's solicitation name, number, and the name of the Respondent on the cover, and shall be clearly titled "Redacted Copy." The Redacted Copy should only redact those portions of material that the Respondent claims are confidential, proprietary, trade secret or otherwise not subject to disclosure.

In the event of a request for public records pursuant to chapter 119, F.S., the Florida Constitution, or other authority, to which documents that are marked as confidential are responsive, the Department will provide the Redacted Copy to the requestor. If a requestor asserts a right to the Confidential Information, the Department will notify the Respondent that such an assertion has been made. It is the Respondent's responsibility to assert that the information in question is exempt from disclosure under chapter 119 or other applicable law. If the Department becomes subject to a demand for discovery or disclosure of the Confidential Information of the Respondent in a legal proceeding, the Department shall give the Respondent prompt notice of the demand prior to releasing the information (unless otherwise prohibited by applicable law). The Respondent shall be responsible for defending its determination that the redacted portions of its response are confidential, proprietary, trade secret, or otherwise not subject to disclosure.

By submitting a response to this RFI, the Respondent agrees to protect, defend, and indemnify the Department for any and all claims arising from or relating to the Respondent's determination that the redacted portions of its reply are confidential, proprietary, trade secret, or otherwise not subject to disclosure. If a Respondent fails to submit a redacted copy of information it claims is confidential, the Department is authorized to produce the entire documents, data, or records submitted to the Department in response to a public records request for these records.

XIV. VENDOR COSTS

Respondents are responsible for all costs associated with the preparation, submission, and any potential meeting to discuss this RFI. The Department will not be responsible for any vendor-related costs associated with responding to this request.

XV. PROCUREMENT OFFICER

If you have questions concerning this RFI, please contact:

Maureen Livings
Departmental Purchasing
Florida Department of Management Services
4050 Esplanade Way, Suite 335
Tallahassee, FL 32399-0950
Phone: 850-410-2404
Email: maureen.livings2@dms.myflorida.com

*****ALL EMAILS TO PROCUREMENT OFFICER SHALL CONTAIN THE RFI NUMBER IN THE SUBJECT LINE OF THE EMAIL*****

XVI. SPECIAL ACCOMMODATIONS

Any person with a disability requiring special accommodations to participate in the RFI shall contact the Department contact person at the phone number above at least five (5) working days prior to the event. If you are hearing or speech impaired, please contact this office by using the Florida Relay Services which can be reached at 1 (800) 955-8771 (TDD).

Certified Business Enterprises are encouraged to participate in the RFI process.